RSC Republican Study Committee
Rep. Jeb Hensarling (R-TX), Chairman
Russ Vought, Executive Director
132 Cannon House Office Building
Washington, DC 20515
www.house.gov/hensarling/rsc
ph (202) 226-9717 / fax (202) 226-1633

RSC Policy Brief:
Medicare Physician Payment Policy

June 23, 2008

The RSC has prepared the following policy brief providing background information on current policies regarding Medicare physician reimbursement.

History and Background: In 1989, the Omnibus Budget Reconciliation Act (P.L. 101-239) established a new physician fee schedule for Medicare, replacing the reasonable charge payment formula that had existed since the program's inception. The fee schedule was designed to alleviate perceived disparities in physician reimbursement levels by more closely tying payment to the amount of resources used for a given service or procedure. The Balanced Budget Act of 1997 (P.L 105-33) modified the fee schedule formula, creating the Sustainable Growth Rate (SGR) mechanism as a means to incorporate cumulative physician spending into reimbursement levels. In addition to slowing the growth of Medicare spending by setting an overall target for physician expenditure levels, the SGR was also intended to eliminate the fluctuations associated with setting annual (as opposed to cumulative) spending targets.

Payment Formula: Under current Medicare law, doctors providing health care services to Part B enrollees are compensated through a "fee-for-service" system, in which physician payments are distributed on a per-service basis, as determined by the fee schedule and an annual conversion factor (a formula dollar amount). The fee schedule assigns "relative values" to each type of provided service, reflecting physicians' work time and skill, average medical practice expenses, and geographical adjustments. In order to determine the physician payment for a specific service, the conversion factor ($38.0870 through June 2008) is multiplied by the relative value for that service. For example, if a routine office visit is assigned a relative value of 2.1, then Medicare would provide the physician with a payment of $79.98 ($38.0870 x 2.1) for that service.

Medicare law requires that the conversion factor be updated each year. The formula used to determine the annual update takes into consideration the following factors:

- Medicare economic index (MEI)–cost of providing medical care;

- Sustainable Growth Rate (SGR)–target for aggregate growth in Medicare physician payments; and
- Performance Adjustment–an adjustment ranging from -13% to +3%, to bring the MEI change in line with what is allowed under SGR, in order to restrain overall spending.

Every November, the Centers for Medicare and Medicaid Services (CMS) announces the statutory annual update to the conversion factor for the subsequent year. The new conversion factor is calculated by increasing or decreasing the previous year's factor by the annual update.

From 2002 to 2007, the statutory formula calculation resulted in a negative update, which would have reduced physician payments, but not overall physician spending. The negative updates occurred because Medicare spending on physician payments increased the previous year beyond what is allowed by SGR. The SGR mechanism is designed to balance the previous year's increase in physician spending with a decrease in the next year, in order to maintain aggregate growth targets. Thus, in light of increased Medicare spending in recent years, the statutory formula has resulted in negative annual updates. It is important to note that while imperfect, the SGR was designed as a cost-containment mechanism to help deal with Medicare's exploding costs, and to some extent it has worked, forcing offsets in some years and causing physician payment levels to be scrutinized annually as if they were discretionary spending.

Since 2003, Congress has chosen to override current law, providing doctors with increases each year, and level funding in 2006. In 2007, Congress provided a 1.5% update bonus payment for physicians who report on quality of care measures, and legislation enacted in December 2007 (P.L. 110-173) provided a 0.5% update for January through June of 2008. The specific data for each year are outlined in the following table.

Year	Statutory Annual Update (%)	Congressional "Fix" to the Update (%)*
2002	-5.4	-5.4**
2003	-4.4	+1.6
2004	-4.5	+1.5
2005	-3.3	+1.5
2006	-4.4	0
2007	-5.0	+1.5***
2008	-10.1	0.5 (Jan.-June)

* The annual update that *actually went into effect* for that year.
** CMS made other adjustments, as provided by law, which resulted in a net update of - 4.8%; however, Congress did not act to override the -5.4% statutory update.
*** The full 1.5% increase was provided to physicians reporting quality of care measures; physicians not reporting quality of care received no net increase.

Because the Tax Relief and Health Care Act (P.L. 109-432), signed into law in December 2006, provided that 2007's Congressional "fix" was to be disregarded for the purpose of calculating the SGR in 2008 and future years, the 10.1% negative annual update for 2008 will be restored once the December 2007 legislation expires on July 1, 2008, absent further Congressional action.

Participation and Assignment: When treating Medicare beneficiaries, physicians may choose to accept assignment on a claim, agreeing to accept Medicare's payment of 80% of the approved fee schedule amount—with the beneficiary paying the remaining 20% as coinsurance—as payment in full for the claim of service. Physicians who agree to accept assignment on *all Medicare claims* in a given year are classified as participating physicians. Physicians classified as non-participating—those who may accept assignment for *some, but not all, claims* in a given year—only receive 95% of the fee schedule amount for participating physicians on those claims for which they accept assignment. The Medicare Payment Advisory Commission (MedPAC) reports that 93.3% of physicians and other providers who bill Medicare agreed to participate in Medicare during 2007, with 99.4% of allowed charges being accepted on assignment from physicians (both participating and non-participating).[1]

In cases where a physician considers the Medicare payment level under the fee schedule and SGR formula an insufficient reimbursement for the time and resources necessary to perform the relevant service, the physician's opportunities to charge beneficiaries the full value of the service performed are extremely limited. Non-participating physicians may "balance bill" beneficiaries for charges above the Medicare fee schedule amount on claims where the physician does not accept assignment from Medicare. However, physicians may not bill beneficiaries in excess of 115% of the non-participating fee schedule amount—which, because Medicare fees are lower for non-participating physicians, has the effect of limiting "balance billing" to 9.25% above the fee schedule amount for participating physicians. Moreover, providers who wish to "balance bill" their beneficiaries in some cases will therefore be classified as non-participating, resulting in a 5% reduction in fee schedule amounts for all claims—including those for which the provider is willing to accept assignment—in a given year.

Conclusion: The Medicare funding warning issued by the plan's trustees last year, and again this past March, provides an opportunity to re-assess the program's structure and finance. These two consecutive warnings—coupled with the trustees' estimate that the Medicare trust fund will be exhausted in just over a decade's time—should prompt Congress to consider ways to reduce the growth of overall Medicare costs, particularly those which utilize competition and consumer empowerment to create a more efficient and cost-effective Medicare program.

Viewed through this prism, the current Medicare physician reimbursement fee schedule may be perceived by some conservatives as symptomatic of the program's larger problems. While the SGR mechanism has provided several opportunities in recent years to review physician payment levels, the changes made by Congress as a result of such reviews have generally only made minor, temporary adjustments to the current system of government-dictated fee schedules. These legislative vehicles have not revamped or repealed the fee schedule formula to take market forces into account, instead delving into the minutiae of provider reimbursement levels to arrive at a short-term fix that meets budgetary muster. However, as Senate Finance Committee Chairman Baucus recently conceded at a health care summit: "How in the world am I supposed to know

[1] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," (Washington, DC, March 2008), available online at http://www.medpac.gov/documents/Mar08_EntireReport.pdf (accessed June 16, 2008), pp. 110-11.

what the proper reimbursement should be for a particular procedure?"[2] Therefore, even though supporting actions that yield budgetary offsets slowing the growth of Medicare spending, some conservatives may still view legislative outcomes that do not comprehensively address the lack of market forces in a government-dictated fee schedule as lacking.

Some conservatives may support legislative provisions designed to repeal prohibitions on "balance billing" by providers, either for all Medicare beneficiaries or only for those beneficiaries already subject to means-testing for their Part B premiums. Such a measure, which has been introduced by several RSC Members in various forms in recent Congresses, would inject some free-market principles into Medicare, by allowing providers to charge reasonable levels for their services rather than adhering to government-imposed price controls. Additionally, this policy change could have the potential to slow the growth of health costs at the margins, by providing slightly greater beneficiary exposure to the true cost of care, which in some cases may be subsidized by the monopsony power Medicare exercises over providers.

On a more fundamental level, some conservatives may also support a premium support model that would convert Medicare into a system similar to the Federal Employees Benefit Health Plan (FEHBP), in which beneficiaries would receive a defined contribution from Medicare to purchase a health plan of their choosing. Previously incorporated into alternative RSC budget proposals, a premium support plan would provide comprehensive reform, while confining the growth of Medicare spending to the annual statutory raise in the defined contribution limit, thus ensuring long-term fiscal stability. Just as important, by potentially shifting the focus of Medicare from a government-run program to a series of private payers, it would reduce or eliminate the need for the seemingly annual ritual of adjustments to Medicare fee schedule amounts, and may ensure that providers receive more reasonable and consistent reimbursement levels. By confining the growth of Medicare spending and limiting the opportunities for Congress to tinker with physician and other reimbursement policies, some conservatives may view a premium support model as a return to the principle of more limited government.

For further information on this issue see:

- *CMS Data on Sustainable Growth Rates*
- *CRS Report on Medicare Physician Payments*

RSC Staff Contact: Chris Jacobs, christopher.jacobs@mail.house.gov, (202) 226-8585

###

[2] Quoted in Anna Edney, "Bernanke: Health Care Reform Will Require Higher Spending," *CongressDailyPM* June 16, 2008, available online at http://www.nationaljournal.com/congressdaily/cdp_20080616_8602.php (accessed June 16, 2008).